FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027052

Facility Name: LAKE PARK CENTER

Address: 919 WASHINGTON PARK (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 623-9100 **Fax #** (847) 623-9179

IDPA ID Number: 36-3109638

Date of Initial License for Current Owners: 02/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,860	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	71,036	579	2,579	74,194	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	71,036	579	2,579	74,194	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.53%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	258,350	12,133	9,029	279,512		279,512		279,512			1
2	Food Purchase		202,972		202,972		202,972	(994)	201,978			2
3	Housekeeping	170,711	37,259		207,970		207,970		207,970			3
4	Laundry	110,435	15,322	2,479	128,236		128,236	205	128,441			4
5	Heat and Other Utilities			180,224	180,224		180,224	522	180,746			5
6	Maintenance	138,997	20,656	33,420	193,073		193,073	(1,854)	191,219			6
7	Other (specify):*			13,439	13,439		13,439	91	13,530			7
8	**TOTAL General Services**	678,493	288,342	238,591	1,205,426		1,205,426	(2,030)	1,203,396			8
	B. Health Care and Programs											
9	Medical Director			4,640	4,640		4,640		4,640			9
10	Nursing and Medical Records	2,158,277	173,258	14,499	2,346,034		2,346,034		2,346,034			10
10a	Therapy	68,133		5,259	73,392		73,392		73,392			10a
11	Activities	99,981	3,954	2,635	106,570		106,570		106,570			11
12	Social Services			3,105	3,105		3,105		3,105			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,326,391	177,212	30,138	2,533,741		2,533,741		2,533,741			16
	C. General Administration											
17	Administrative	97,042		395,000	492,042		492,042	(371,455)	120,587			17
18	Directors Fees											18
19	Professional Services			34,194	34,194		34,194	7,993	42,187			19
20	Dues, Fees, Subscriptions & Promotions			23,066	23,066		23,066	(3,831)	19,235			20
21	Clerical & General Office Expenses	81,664	18,438	151,167	251,269		251,269	(97,888)	153,381			21
22	Employee Benefits & Payroll Taxes			450,009	450,009		450,009		450,009			22
23	Inservice Training & Education			3,135	3,135		3,135	83	3,218			23
24	Travel and Seminar			7,426	7,426		7,426		7,426			24
25	Other Admin. Staff Transportation			9,143	9,143		9,143	833	9,976			25
26	Insurance-Prop.Liab.Malpractice			78,745	78,745		78,745	655	79,400			26
27	Other (specify):*							6,401	6,401			27
28	**TOTAL General Administration**	178,706	18,438	1,151,885	1,349,029		1,349,029	(457,209)	891,820			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,183,590	483,992	1,420,614	5,088,196		5,088,196	(459,239)	4,628,957			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,160	
	REPAIRS & MAINTENANCE		869	
			0	9,029
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,479	
			0	2,479
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		58,657	
	ELECTRICITY		53,135	
	WATER		68,432	
	CABLE TV - LOBBY		0	
			0	180,224
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,770	
	PAINTING & DECORATING		9,626	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,107	
	ELEVATOR MAINTENANCE & REPAIR		6,288	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,245	
	FIRE SERVICE		5,384	
			0	
			0	
			0	33,420
7	**OTHER**			
	SCAVENGER		8,039	
	SECURITY SERVICE		5,400	13,439
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,640	4,640

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		460	
	PURCHASED SERVICES		588	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	6,651	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	3,200	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,600	
			0	14,499
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,190	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,069	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,259
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,635	
			0	2,635
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,105	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,105
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	395,000	395,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	16,421	
	ADMINISTRATIVE CONSULTANTS	XIX C	2,000	
	PROFESSIONAL FEES	XIX C	15,773	
			0	34,194
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	3,989	
	CONTRIBUTIONS	VI 20 XIX F	500	
	DUES & SUBSCRIPTIONS	XIX F	6,785	
	LICENSES & PERMITS	XIX F	6,926	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	1,075	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	3,421	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	370	23,066
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		27	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		105,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	65	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,225	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		30,250	151,167

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	235,910	
	UNEMPLOYMENT COMPENSATION	XIX D	21,931	
	WORKERS COMPENSATION INSURANCI	XIX D	71,879	
	HOSPITALIZATION INSURANCE	XIX D	86,377	
	EMPLOYEE BENEFITS - OTHER	XIX D	500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	33,412	
	CHICAGO HEAD TAX	XIX D	0	450,009
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,135	3,135
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	7,426	
			0	
			0	7,426
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		9,143	9,143
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		78,745	78,745
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,420,614

LAKE PARK CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	202,972	PATIENT MEALS	222582
LESS SALES TAX	(994)	ADD EMPLOYEE MEALS	0
NET FOOD	201,978	TOTAL MEALS/YEAR	222582
TOTAL PATIENT CENSUS	74,194	NET FOOD	201978
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	222582
TOTAL PATIENT MEALS	222582	COST PER MEAL	0.91
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number LAKE PARK CENTER #0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			111,943	111,943		111,943	395,688	507,631			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,848	2,848		2,848	476,050	478,898			32
33	Real Estate Taxes			1,457	1,457		1,457	132,303	133,760			33
34	Rent-Facility & Grounds			667,668	667,668		667,668	(667,668)				34
35	Rent-Equipment & Vehicles			26,368	26,368		26,368	5,971	32,339			35
36	Other (specify):* OFFICE RENT			16,380	16,380		16,380	(16,380)				36
37	**TOTAL Ownership**			826,664	826,664		826,664	325,964	1,152,628			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,290	115,290		115,290		115,290			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			115,290	115,290		115,290		115,290			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,183,590	483,992	2,362,568	6,030,150		6,030,150	(133,275)	5,896,875			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(61,988)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(994)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,075)	20		17
18	Fines and Penalties	(65)	21		18
19	Entertainment		20		19
20	Contributions	(3,921)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5-A	(35,832)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,875)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(29,400)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (29,400)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (133,275)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

LAKE PARK CENTER

ID# 0027052

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -5582	6	1
2	STAFF DEVELOPMENT	(30,250)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(35,832)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(994)	0	0	0	0	0	0	0	0	0	0	(994)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	205	0	0	0	0	0	0	0	0	205	4
5	Heat and Other Utilities	0	522	0	0	0	0	0	0	0	0	0	522	5
6	Maintenance	(5,582)	1,319	2,409	0	0	0	0	0	0	0	0	(1,854)	6
7	Other (specify):*	0	55	36	0	0	0	0	0	0	0	0	91	7
8	**TOTAL General Services**	(6,576)	1,896	2,650	0	0	0	0	0	0	0	0	(2,030)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	7,970	(379,425)	0	0	0	0	0	0	0	(371,455)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	83	7,722	188	0	0	0	0	0	0	0	7,993	19
20	Fees, Subscriptions & Promotions	(4,996)	0	1,165	0	0	0	0	0	0	0	0	(3,831)	20
21	Clerical & General Office Expenses	(30,315)	230	(76,887)	9,084	0	0	0	0	0	0	0	(97,888)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	83	0	0	0	0	0	0	0	0	83	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	571	262	0	0	0	0	0	0	0	833	25
26	Insurance-Prop.Liab.Malpractice	0	274	381	0	0	0	0	0	0	0	0	655	26
27	Other (specify):*	0	0	5,149	1,252	0	0	0	0	0	0	0	6,401	27
28	**TOTAL General Administration**	(35,311)	587	(53,846)	(368,639)	0	0	0	0	0	0	0	(457,209)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,887)	2,483	(51,196)	(368,639)	0	0	0	0	0	0	0	(459,239)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(61,988)	1,597	305	455,774	0	0	0	0	0	0	0	395,688	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	2,078	0	473,972	0	0	0	0	0	0	0	476,050	32
33	Real Estate Taxes	0	2,238	0	130,065	0	0	0	0	0	0	0	132,303	33
34	Rent-Facility & Grounds	0	0	0	(667,668)	0	0	0	0	0	0	0	(667,668)	34
35	Rent-Equipment & Vehicles	0	158	5,056	757	0	0	0	0	0	0	0	5,971	35
36	Other (specify):*	0	(16,380)	0	0	0	0	0	0	0	0	0	(16,380)	36
37	**TOTAL Ownership**	(61,988)	(10,309)	5,361	392,900	0	0	0	0	0	0	0	325,964	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(103,875)	(7,826)	(45,835)	24,261	0	0	0	0	0	0	0	(133,275)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
				IME REALTY CORP.	LINCOLNWOOD	HOME OFFICE
				WAUKEGAN PRO-		
				PERTIES, LLC	LINCOLNWOOD	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	36	OFFICE RENT	$ 16,380	IME REALTY CORP.		$	$ (16,380)	1
2	V	5	UTILITIES				522	522	2
3	V	6	REPAIRS/MAINT				1,319	1,319	3
4	V	19	PROFESSIONAL FEES				83	83	4
5	V	21	OFFICE EXPENSE				230	230	5
6	V	26	INSURANCE				274	274	6
7	V	30	DEPRECIATION (SL)				1,597	1,597	7
8	V	32	INTEREST				2,078	2,078	8
9	V	33	RE TAXES				2,238	2,238	9
10	V	35	STORAGE FEES				158	158	10
11	V	7	ALARM SERVICE				55	55	11
12	V								12
13	V								13
14	Total			$ 16,380			$ 8,554	$ * (7,826)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 105,600	EKS MANAGEMENT CO.		$	$ (105,600)	15
16	V	6	PAINTERS SALARIES				2,409	2,409	16
17	V	7	SCAVENGER				36	36	17
18	V	17	CFO SALARY				7,970	7,970	18
19	V	19	PROFESSIONAL FEES				7,722	7,722	19
20	V	20	WANT ADS/BACKGR CKS				1,165	1,165	20
21	V	21	TOTAL OFFICE				28,713	28,713	21
22	V	23	SEMINARS				83	83	22
23	V	25	TRANSPORTATION				571	571	23
24	V	26	INSURANCE				381	381	24
25	V	27	EMPLOYEE BENEFITS				5,149	5,149	25
26	V	30	DEPRECIATION (SL)				305	305	26
27	V	35	EQUIPMENT RENT				5,056	5,056	27
28	V	4	HOUSEKEEPING SALARIES				205	205	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 105,600			$ 59,765	$ * (45,835)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 395,000	EMI ENTERPRISES INC.		$	$ (395,000)	15
16	V	17	OFFICERS SALARY				15,575	15,575	16
17	V	19	ACCOUNTING FEES				188	188	17
18	V	21	TOTAL OFFICE				9,084	9,084	18
19	V	25	TRANSPORTATION				262	262	19
20	V	35	AUTO LEASE				757	757	20
21	V	27	EMPLOYEE BENEFITS				1,252	1,252	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34	RENT	667,668	WAUKEGAN TERRACE PROPERTIES LLC			(667,668)	27
28	V	33	REAL ESTATE TAX				130,065	130,065	28
29	V	30	DEPRECIATION (SL)				455,774	455,774	29
30	V	32	INTEREST				473,972	473,972	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,062,668			$ 1,086,929	$ * 24,261	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GENERAL PTR	ADMINISTRATIV	47.62		SEE ATTACHED		SALARY	$ 15,575	17-8	1
2	AVRUM WEINFELD	CFO	CFO	1.43		SCHEDULE		SALARY	7,970	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 23,545		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	881,303	14	$ 28,615	$	74,194	$ 2,409	1
2	7	SCAVENGER	PATIENT DAYS	881,303	14	429		74,194	36	2
3	17	CFO SALARY	PATIENT DAYS	881,303	14	94,671		74,194	7,970	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	881,303	14	91,723	65,670	74,194	7,722	4
5	20	WANT ADS / BACKGR CKS	PATIENT DAYS	881,303	14	13,841		74,194	1,165	5
6	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	341,059	251,740	74,194	28,713	6
7	23	SEMINARS	PATIENT DAYS	881,303	14	984		74,194	83	7
8	25	TRANSPORTATION	PATIENT DAYS	881,303	14	6,783		74,194	571	8
9	26	INSURANCE	PATIENT DAYS	881,303	14	4,521		74,194	381	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	61,166		74,194	5,149	10
11	30	DEPRECIATION (SL)	PATIENT DAYS	881,303	14	3,617		74,194	305	11
12	35	EQUIPMENT RENT	PATIENT DAYS	881,303	14	60,061		74,194	5,056	12
13	4	HOUSEKEEPING SALARIES	PATIENT DAYS	881,303	14	2,437		74,194	205	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 709,907	$ 317,410		$ 59,765	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847)675-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	312,263	16	$ 9,942	$	16,380	$ 522	1
2	6	REPAIRS/MAINT	PATIENT DAYS	312,263	16	25,152		16,380	1,319	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	312,263	16	1,575		16,380	83	3
4	21	OFFICE EXPENSE	PATIENT DAYS	312,263	16	4,388		16,380	230	4
5	26	INSURANCE	PATIENT DAYS	312,263	16	5,225		16,380	274	5
6	30	DEPRECIATION (SL)	PATIENT DAYS	312,263	16	30,446		16,380	1,597	6
7	32	INTEREST	PATIENT DAYS	312,263	16	39,616		16,380	2,078	7
8	33	RE TAX	PATIENT DAYS	312,263	16	42,669		16,380	2,238	8
9	35	STORAGE FEES	PATIENT DAYS	312,263	16	3,011		16,380	158	9
10	7	ALARM SERVICE	PATIENT DAYS	312,263	16	1,056		16,380	55	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 163,080	$		$ 8,554	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	881,303	14	$ 185,000	$ 185,000	74,194	$ 15,575	1
2	19	ACCOUNTING FEES	PATIENT DAYS	881,303	14	2,230		74,194	188	2
3	21	TOTAL OFFICE	PATIENT DAYS	881,303	14	107,899	87,197	74,194	9,084	3
4	25	TRANSPORTATION	PATIENT DAYS	881,303	14	3,109		74,194	262	4
5	35	AUTO LEASE	PATIENT DAYS	881,303	14	8,991		74,194	757	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	881,303	14	14,871		74,194	1,252	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 322,100	$ 272,197		$ 27,118	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: WAUKEGAN TERRACE PROPERTIES, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$75,123.97	04/04	10,324,600	10,164,768	04/39	5.1400	469,493	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN			196,242			4,479	3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	DEMAND		500,000	609,000		PRIME+	2,848	6
7												7
8	MGMT ALLOCATION										2,078	8
9	TOTAL Facility Related						$ 10,824,600	$ 10,970,010			$ 478,898	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,824,600	$ 10,970,010			$ 478,898	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	122,414	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	123,871	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,457	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	130,065	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	131,522	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	88,164	8
2000	91,441	9
2001	107,989	10
2002	121,202	11
2003	123,871	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 105% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE PARK CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027052

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	NURSING HOME	$ 123,871.42	$ 123,871.42
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 123,871.42	$ 123,871.42

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,175 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			2003	$ 1,050,000	1
2					2
3	TOTALS			$ 1,050,000	3

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	210		2003	1967	$ 8,144,786	$ 296,174	27.5	$ 296,174	$	$ 357,877	4
5											5
6											6
7											7
8	IME ALLOCATION					1,534		1,534			8
	Improvement Type**										
9	PAINTING			1986	15,680		15			15,680	9
10	ASHALT PAVING			1987	8,180	260	31.5		(260)	8,180	10
11	AVAC UNITS			1988	45,000	1,429	31.5	1,429		34,850	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		27,361	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		8,748	13
14	PARKING LOTS			1993	19,440	1,296	15	1,296		14,588	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	46		604	15
16	NURSE STATION			1993	7,800	200	31.5	200		2,622	16
17	ELEVATOR			1994	22,300	572	39	572		5,982	17
18	CUBICLE CURTAINS			1994	843	22	39	22		237	18
19	PARKING LOTS LIGHTS			1995	8,677	578	15	578		5,491	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		2,365	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		1,695	21
22	TILE			1996	20,387	522	39	522		4,330	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		1,155	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		2,117	24
25	TWO SHOWERS			1998	2,720	70	39	70		475	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		1,621	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		5,323	27
28	WATER HEATER			1998	4,639	119	39	119		729	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		649	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		3,580	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		2,400	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		1,138	32
33	FIRE DAMPERS			2000	8,070	293	20	293		1,331	33
34	FENCE			2000	6,810	477	15	477		1,961	34
35	CUBICLE CURTAINS			2001	14,018	1,615	20	701	(914)	2,804	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	253	27.5	253		1,012	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINT ALL INTERIOR WALLS	2001	$ 2,800	$ 102	27.5	$ 102	$	$ 408	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895	5,172	20	2,245	(2,927)	8,980	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	1,048	27.5	1,048		4,192	39
40	ROOF TOP UNITS	2001	12,900	469	27.5	469		1,876	40
41	INSTALLATION OF FOUR ROOFTOP UNITS	2002	35,152	1,278	27.5	1,278		2,716	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,675,814	$ 319,468		$ 315,367	$ (4,101)	$ 535,077	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 279,542	$ 25,728	$ 26,925	$ 1,197	10 YRS	$ 144,858	71
72	Current Year Purchases	107,425	64,455	5,371	(59,084)	10 YRS	5,371	72
73	Fully Depreciated Assets	233,897					233,897	73
74	RELATED PARTY SL DEPR		159,968	159,968				74
75	TOTALS	$ 620,864	$ 250,151	$ 192,264	$ (57,887)		$ 384,126	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,346,678	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 569,619	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 507,631	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (61,988)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 919,203	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 9,308 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2003 FORD E350	$ 699.00	$ 8,391	17
18	MAINTENANCE	2004 FORD F150	599.00	6,732	18
19	PAINTERS	2003 CHEV ASTRO VAN	645.00	1,937	19
20					20
21	TOTAL		$ #######	$ 17,060	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs			N/A				8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (6,024)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,878,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	95,568		6
7	Other Prepaid Expenses	18,293		7
8	Accounts Receivable (owners or related parties)	401,788		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,388,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	531,028		15
16	Equipment, at Historical Cost	620,864		16
17	Accumulated Depreciation (book methods)	(740,417)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 411,475	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,799,711	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 165,579	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	644,000		29
30	Accrued Salaries Payable	106,554		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,969		31
32	Accrued Real Estate Taxes(Sch.IX-B)		130,065	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO WAUKEGAN LLC	81,307		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,041,409	$ 130,065	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,041,409	$ 130,065	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,758,302	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,799,711	$ 130,065	48

*(See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,711,993	1
2	Restatements (describe):		2
3	ROUNDING	3	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,711,996	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	823,269	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(776,963)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 46,306	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,758,302	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,856,406	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,856,406	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17,911	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,911	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,874,317	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,205,426	31
32	Health Care	2,533,741	32
33	General Administration	1,349,029	33
	B. Capital Expense		
34	Ownership	826,664	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	115,290	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,030,150	40
41	**Income before Income Taxes (line 30 minus line 40)****	844,167	41
42	**Income Taxes**	(20,898)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 823,269	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,706	1,958	$ 54,919	$ 28.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	24,550	26,542	708,753	26.70	3
4	Licensed Practical Nurses	6,299	6,768	161,878	23.92	4
5	Nurse Aides & Orderlies	105,207	111,413	1,212,664	10.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,167	5,837	68,133	11.67	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,984	10,690	99,981	9.35	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,036	27,731	258,350	9.32	15
16	Dishwashers					16
17	Maintenance Workers	10,328	10,669	138,997	13.03	17
18	Housekeepers	21,950	22,798	170,711	7.49	18
19	Laundry	11,293	12,508	110,435	8.83	19
20	Administrator	2,103	2,103	97,042	46.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,060	8,296	81,664	9.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Quality Assurance	1,684	1,684	20,063	11.91	33
34	TOTAL (lines 1 - 33)	234,367	248,997	$ 3,183,590 *	$ 12.79	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 8,160	1-3	35
36	Medical Director	monthly fee	4,640	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	6,651	10-3	39
40	Physical Therapy Consultant	62	3,190	10a-3	40
41	Occupational Therapy Consultant	40	2,069	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	52	2,635	11-3	44
45	Social Service Consultant	58	3,105	12-3	45
46	Other(specify) PSYCHIATRIC	monthly fee	3,200	10-3	46
47	DENTAL	monthly fee	3,600	10-3	47
48					48
49	TOTAL (lines 35 - 48)	212	$ 37,250		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LIVINGS	ADMIN	0	$ 97,042
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,042

B. Administrative - Other

Description		Amount
EMI ENTERPRISES, INC	MANAGEMENT FEES	$ 395,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 395,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,276
WESTMONT	DATA PROCESSING	800
LTC SOLUTIONS	DATA PROCESSING	550
MAXXSOURCE	DATA PROCESSING	1,174
NCS	DATA PROCESSING	9,022
HEALTH DATE	DATA PROCESSING	599
KBKB	ACCOUNTING	11,100
STONE, MCGUIRE, BENJAMIN	LEGAL	3,648
HOLLAND & KNIGHT	LEGAL	229
PERSONNEL PLANNERS	U.C. CONSULTANT	796
PHILIP ESFORMES, INC	ADMIN CONSULTANT	2,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,194

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 71,879
Unemployment Compensation Insurance		21,931
FICA Taxes		235,910
Employee Health Insurance		86,377
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		500
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		33,412
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 450,009

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 6,200
Advertising: Employee Recruitment	3,989
Health Care Worker Background Check	370
(Indicate # of checks performed 26)	
MARKETING/ADV/PROMO	0
TRUST/FRANCHISE/CONTRIB/ETC	4,996
LICENSES & PERMITS	726
DUES & SUBSCRIPTIONS	6,785
MGMT CO ALLOCATION	1,165
TRUST/FRANCHISE/CONTRIB/ETC	(4,996)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,235

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
FLORIDA	7,426
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,426

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2003	$ 7,319	3 YRS	$	$	$ 1,220	$ 2,440	$ 2,440	$ 1,219	$	$	$
2	PAINTING/DECORATIN	2004	9,626	3 YRS				1,604	3,209	3,209	1,604		
3													
4													
5													
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16													
17													
18													
19													
20	TOTALS		$ 16,945		$	$	$ 1,220	$ 4,044	$ 5,649	$ 4,428	$ 1,604	$	$

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $6,785**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **156** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,290**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees